UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

GROWTH HORMONE ADULT-AIDS

Patient name:_____Medicaid or SS#_____
Physician Name:_____ Contact person:_____
Phone#:_____Ext and options_____Fax#_____
Pharmacy_____Pharmacy Phone#:_____
Diagnosis_____

All information to be legible, complete and correct or form will be returned

FAX REQUIRED DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

- Adult age 19 and over
- Adult onset - AIDS Wasting indication only.
- Body Mass Index is less than 20, BMI = wt times 704 divided by height squared (in inches)
- Patient must be taking antiretroviral medications
- Initial weight_____, Initial Height_____, Weight after 60 day trial_____
- Rule out causes of weight loss including hypogonadism, opportunistic infections, diarrhea, inadequate nutritional intake, malabsorption, and thyroid abnormalities.
- (For men) Rule out hypotestosterone levels since hypogonadism is common among HIV infected individuals.
- Patient must be able to maintain 100% of daily nutritional intake. For patients receiving enteral or parenteral nutrition, the patient must be weight stable for two months.
- Patient must not have an untreated or suspected systemic infection or persistent fever > 101 F during the 30 days prior to evaluation of weight loss.
- Patient must not have any signs or symptoms of gastrointestinal malabsorption or blockage unless on total parenteral nutrition
- Patient must not have active malignancy, except for Kaposi's Sarcoma (KS).

AUTHORIZATION:

Initial trial 60 days.

RE-AUTHORIZATION:

Fax copy of current prescription and history and physical showing weight gain during trial period. With appropriate progress, the patient may receive an additional four weeks of therapy. If the patient continues to show progress, additional prior authorizations are granted in six week periods only to a maximum of twelve weeks per any six month episode.